# FERMI NATIONAL ACCELERATOR LABORATORY
## GROUP EMPLOYEE BENEFITS
## BENEFIT ACTION FORM

CHECK ONE: ☐ NEW EMPLOYEE ☐ REHIRE ☐ REINSTATEMENT ☐ COBRA

CHECK CHANGE: ☐ BENEFICIARY ☐ ADD DEPENDENT ☐ DELETE DEPENDENT ☐ ADDRESS
☐ MARRIAGE ☐ BIRTH ☐ ADOPTION ☐ DIVORCE

ID _____ LAST NAME _____ FIRST NAME _____ M.I. _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____ HOME PHONE NUMBER _____

## MEDICAL COVERAGE

**CHECK ONE**

☐ CIGNA Open Access Plus
☐ CIGNA Network POS
☐ HMO Illinois
☐ BLUE Advantage HMO
☐ WAIVE COVERAGE

**OFFICE USE ONLY**

Benf Class/Sec Code: FACT
Benf Class/Sec Code: FACT Cigna Ben.Code: 100IL053
Benf Class/Sec Code: OOOO
Benf Class/Sec Code: OOOO
Coverage Change Effective Date: _____

I waive coverage because I and/or my dependents have medical coverage under another medical plan. I understand by refusing coverage that I can subsequently enroll only during an open enrollment period or when I qualify under special enrollment requirements under the Health Insurance Portability and Accountability Act of 1999.

## LEVEL OF COVERAGE

**CHECK ONE**

☐ Employee Only
☐ Family

**OFFICE USE ONLY**
**Effective Date**

| Coverage | Deduction |
|---|---|
| Employee | Employee |
| Family | Family |

**INITIAL ENROLLMENT:** List below yourself and all eligible dependents you are enrolling in your **medical plan**.
**ADDING DEPENDENT(S) TO COVERAGE:** List below only the new dependent(s) you are adding to your **medical plan**.
**DROPPING DEPENDENT(S) FROM COVERAGE:** List below only the dependent(s) you are dropping from your **medical plan** and write "cancel" next to their name(s).

| Name: Last / First / M.I. | Social Security Number (if available) | Sex | DOB | BLUE ADVANTAGE, HMO IL & POS Primary Care MD Name | BLUE ADVANTAGE, HMO IL 2-4 digit ID# or POS MD# |
|---|---|---|---|---|---|
| SELF: | | | | | |
| SP: | | | | | |
| C1: | | | | | |
| C2: | | | | | |
| C3: | | | | | |

## DENTAL COVERAGE

**CHECK ONE**

☐ CIGNA Dental PPO
☐ CIGNA Dental Health (HMO)
☐ WAIVE COVERAGE

**OFFICE USE ONLY**

Benf Class/Sec Code: FACT
Benf Class/Sec Code: FACT
Coverage Change Effective Date: _____

If you are waiving dental coverage for yourself or your dependents (including your spouse), you can only subsequently enroll at the next open enrollment or when you qualify under special enrollment requirements under the Health Insurance Portability and Accountability Act of 1999.

## LEVEL OF COVERAGE

**CHECK ONE**

☐ Employee Only
☐ Family

**OFFICE USE ONLY**
**Effective Date**

| Coverage | Deduction |
|---|---|
| Employee | Employee |
| Family | Family |

**INITIAL ENROLLMENT:** List below yourself and all eligible dependents you are enrolling in your **dental plan**.
**ADDING DEPENDENT(S) TO COVERAGE:** List below only the new dependent(s) you are adding to your **dental plan**.
**DROPPING DEPENDENT(S) FROM COVERAGE:** List below only the dependent(s) you are dropping from your **dental plan** and write "cancel" next to their name(s).

| Name: Last / First / M.I. | Social Security Number (if available) | Sex | DOB | CIGNA DENTAL HEALTH (HMO) ENTER 6 DIGIT DENTAL OFFICE # BELOW |
|---|---|---|---|---|
| SELF: | | | | |
| SP: | | | | |
| C1: | | | | |
| C2: | | | | |
| C3: | | | | |

**(OVER)**

**OFFICE USE ONLY**

| | Effective Date | Vacation Schedule |
|---|---|---|
| ☐ LONG TERM DISABILITY INSURANCE | _____ | ☐ Exempt 97 |
| ☐ SICK LEAVE | _____ | ☐ Exempt 1 URA/FFRDC |
| ☐ VACATION | _____ | ☐ NE 97 |
| ☐ FLOATING HOLIDAY | _____ | ☐ NE |

**CONNECTICUT GENERAL GROUP LIFE INSURANCE OPTIONS**

**Employee Coverage** **Dependent Coverage**

Mark no more than one option from each category below

☐ BASIC (No Charge) – 1 x salary ☐ OPTION A (spouse $5,000/children $2,000)

☐ SUPPLEMENTAL I – 2 x salary

☐ SUPPLEMENTAL II – 3 x salary ☐ OPTION B (spouse $10,000/children $4,000)

☐ SUPPLEMETLAL III * – 4 x salary

☐ SUPPLEMENTAL IV * – 5 x salary

* Medical evidence of insurability required, contact Benefits Office at extension 3395, 4361, or 4362 for Cigna insurance application.

**OFFICE USE ONLY**

**Effective date**

| Coverage | Deduction | Coverage | Deduction |
|---|---|---|---|
| Employee Guaranteed | Employee Guaranteed | Dependent | Dependent |
| Employee EOI appv date | Employee EOI appv date | | |

☐ **AD&D Effective Date** _____

**LIFE INSURANCE BENIFICIARY** **BENEFIT AMOUNT**

| PRIMARY BENEFICIARY: Last/First/M.I. | Relationship | SEX | DOB | % or | Flat Amt. |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| SECONDARY BENEFICIARY: Last/First/M.I. | Relationship | SEX | DOB | % or | Flat Amt. |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**LIST NAME, ADDRESS, AND PHONE NUMBER OF DEPENDENTS OR BENEFICIARIES WITH AN ADDRESS DIFFERENT THAN YOURS (IF KNOWN) IN THE SPACE PROVIDED BELOW**

The above beneficiaries apply to the employee's coverage. The employee is the beneficiary of the dependent coverage. Unless otherwise provided, where two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries, if surviving the insured, or to the survivor or survivors. If no beneficiary survives, payment shall be made in accordance with the terms of the policy. This designation revokes any and all previous designations. The right to further change the beneficiary is reserved to the insured.

**EMPLOYEE NOTIFICATION**

Single employees are eligible to select only one health plan. Married employees are eligible to select only one health plan for themselves and their dependents. (If husband and wife are both employees of URA/Fermilab, they cannot be covered under more than one health plan. Each can be in a separate plan, but each cannot be covered under two plans. Their eligible children are covered as dependents of only one parent.)

**EMPLOYEE AUTHORIZATION AND CERTIFICATION**

I authorize Fermilab to deduct from my paycheck the appropriate contributions, if any, to the employee benefit plans that I have elected. Contributions for medical and dental coverage will be done on a before tax basis unless the employee signs a waiver form. I hereby certify that the information that I have provided on this form is true and correct to the best of my knowledge.

EMPLOYEE SIGNATURE _____ DATE _____ BENEFITS OFFICE _____ DATE _____